

The operator then works his way with the finger and periosteal elevator beneath the skin till the first gland is reached; it is seized with a volsella and dissected free with the finger and elevator. The head should be turned to the affected side during the operation, and any gland attached to the jugular vein should be brought to the external wound and carefully removed.

TRAUMATIC EPILEPSY.

LE DENTU gives (*La Presse Médicale*, June 9, 1894) the following as the known causes of traumatic epilepsy:

1. Fragments of bone resulting from the fracture of the skull; these may cause epileptiform convulsions immediately after the trauma.
2. Bony outgrowths due to traumatism of the cranium may cause epilepsy. This is, however, a rare event, as when a slow compression occurs the brain accommodates itself to the new conditions.
3. Meningeal cicatrices, following lacerations of the membranes by bony fragments. They are at first soft, but later are apt to become hard and adhere to the surface of the brain, when they are capable of determining epileptiform attacks.
4. It is the same with incipient chronic meningitis, which ends in sclerosis of the membranes.
5. Cysts resulting from intracranial hemorrhages occurring at the point of the fracture may cause attacks of epilepsy.
6. Arterio-venous aneurism. A case of this kind has been described by Warnots, of Brussels. He diagnosticated a blood cyst in a case of epilepsy which had been preceded by traumatism, and on opening the skull found the above lesion. The bone was not replaced, but the scalp was sutured. The patient was cured.

In operating for traumatic epilepsy it is not sufficient to remove a disk of bone; but if no lesion is found, the dura should be incised to permit of inspection of the subjacent parts, and even incision of the cortex of the brain may be practised, although the latter is generally followed by more or less lasting paralysis.

ON THE MODE OF DEATH IN CEREBRAL COMPRESSION, AND ITS PREVENTION.

VICTOR HORSLEY calls renewed attention in the *Quarterly Medical Journal*, 1894, vol. ii., part iv., to the fact that in fatal cases of cerebral compression death is due to respiratory failure. This has been experimentally demonstrated by a number of investigators, among the most recent of whom are Spencer and the author. Their results led them to the general conclusion that a rise of pressure within the skull caused a slowing and diminution of the respiratory movements, and later arrest of the same.

The three common causes of increased intra-cranial tension which have been submitted to surgical treatment are cerebral tumors, hemorrhage, and inflammatory foci. In each of these sudden death is apt to occur from arrest of respiration, unless the pressure be relieved by trephining.

Four cases of intra-cranial tumor—three of the cerebrum and one of the cerebellum—are cited in illustration of the subject. In one of these death

resulted from respiratory failure on the morning of the day appointed for the operation. In the other three cases the failure of respiration occurred on the table during the operation for the relief of the cerebral condition. In each instance the patient turned suddenly white, the respiration became extremely shallow for a few breaths, and then stopped altogether. Artificial respiration was at once resorted to, and the skull rapidly and adequately opened over the supposed site of the tumor with the trephine and bone forceps. In every instance normal respiration returned, the movements being a little shallow at first, but soon assuming their customary proportions.

In experimenting on monkeys Horsley found that hot irrigations (100° to 105° F.) were very beneficial in removing the shock of the operative procedure and in restoring the activity of the respiratory centre. He therefore has an assistant irrigate the head freely with bichloride of mercury—about 1 : 10,000—at the temperature mentioned during these operations. In this connection he expresses doubt whether the routine treatment of applying an ice bag in head injuries ought not to be given up.

Attention is directed to the class of cases in which a person receiving a blow on the occipito-temporal region falls unconscious and dies, or, as is said, falls dead. Death results in these cases, according to Horsley, from respiratory arrest, and they are eminently cases requiring artificial respiration, although this seems to have been entirely ignored heretofore.

In concluding the author states that of all of the lower nerve centres which are necessary to the functions of so-called organic life, the respiratory centre is the most sensitive to mechanical pressure and shocks; that where death results in cases of intra-cranial pressure, artificial respiration should be immediately performed, and the skull opened freely at once; that in cases of sudden shock artificial respiration should be directly instituted, and that in every case heat should be applied to the head—preferably by irrigation.

ON RESECTION OF THE CARDIA.

Under this heading LEVY describes in the *Centralblatt für Chirurgie*, 1894, No. 31, an operation which he has devised for removing the œsophageal extremity of the stomach. Resection of the pylorus has now become a not uncommon operation, and the author has sought to confer the same benefits on those patients suffering from malignant disease of the cardiac extremity as are offered those in which the disease is located in the pylorus. So far, the operation has been performed on cadavers and dogs only. An exhaustive communication is promised later; the object of the present writing is briefly to outline his method, which is as follows:

1. Incision through the abdominal wall, beginning in the middle line at the ensiform cartilage and extending to a finger's breadth below the navel, which is passed on its left side, and from this extremity of the wound a second incision is carried at a right angle through the right rectus muscle.

2. Isolation of the cardia. The wound is held open by retractors, the liver pushed to the right and above, and the stomach drawn downward and to the left. The small curvature and the lesser omentum then become visible. The latter is then cut through on the left side (the portion adjacent to the cardia), and double ligatures applied to the arteria and vena coronaria